Urgent Care as a Specialty:

Will we ever see urgent care be recognized as a specialty? This is a question that many members of the College have been asking themselves for years. Quite frankly, we at the College have always had some discussion about this from time to time, as it relates directly to our vision. We, however, have never found a great answer on how to accomplish this. We continue to have discussions, and we end up at the same place where we started and asking the same question: Will our industry ever be recognized as a specialty? Lately, we have taken a step back and asked ourselves another question: Do we even want to pursue this path? There are pros and cons to pursuing this vision. The first question that we need to answer as a group is whether we even want to pursue this path. Do we even want to go down the path of developing a specialty, or are we as a group satisfied with where we are right now?

Urgent care providers come from a variety of clinical backgrounds. Mostly, these include providers from family medicine and emergency medicine specialties. Then there are other providers from internal medicine, pediatrics, etc. Some might argue that they see urgent care as more of a business model rather than a clinical specialty, and they would like to continue to keep their primary board certifications in their primary specialty while working in urgent care. This might give them the flexibility to go back to their primary specialty if they so desire at some point in their career. Some, on the other hand, might argue that they have now chosen urgent care as their lifelong career and would like to see it become a specialty so that it gets the appropriate recognition in the medical community which would enable providers to get better contracts and also be better recognized for the work that they do on a daily basis.

Developing a specialty and getting it recognized is an enormous task. There are many objectives that need to be accomplished in order to reach to the final goal. For one, a specialty needs to have formal training programs. We also need to have our own board exams that help certify our providers. We also need to have original research within urgent care. There are other requirements as well. If we do work on developing our own specialty boards that are recognized, then would that make a difference for the providers, who might still be required to hold other board certifications because of certain credentialing requirements for their insurance and hospital contracts? In that situation, would the providers be willing to give a board exam that might change their current requirements? After all, this is medicine that we are talking about and our ways of functioning usually do not change overnight!!

There are many such questions that need to be answered. This is a very complicated topic, at least for now. We would love to hear from each one of you regarding your thoughts about this. I would like to invite you to discuss this topic on the College's Listserv. I would love to hear your thoughts. You can post your thoughts on the Listserv via: cucm@listserv.coucm.org. Looking forward to a great discussion.

Contact Dr. Jasmeet Bhogal: dr_jsbhogal@yahoo.com

EDITOR'S CORNER - Sean M McNeeley, MD, FCUCM

Fall is Coming

Once again, Dr. Bhogal has left me little room to comment. On July 21 we will be having our 2nd COVID-19 Town Hall meeting (video of 1st Town Hall: https://youtu.be/mHj3fKYbpG8). One of the focuses will be “how do we manage the challenges this fall will present?” Influenza, strep, gastroenteritis and even the common cold will be back and it looks like COVID-19 is not going away before then. Triage, testing, treatment choices are all going to be a challenge. Dealing with an influx of patients and remaining socially distanced will strain our center. Are you ready? Come chat with us on 7/21: Register to join the Town Hall at https://bit.ly/3j0s3gH

Contact Dr. McNeeley: sean.mcneeley@uhhospitals.org
5TH METACARPAL BASE AVULSION FRACTURE
Cesar Mora Jaramillo, MD

CASE:
Patient is a 16-year-old male who presents to the urgent care with right hand pain after punching a wall. He rates pain as 8/10 and reports moderate hand edema with mild hand numbness. He denies any skin abrasions but reports 4th and 5th finger flexion increases pain.

Physical exam:
Vital signs are within normal limits. Patient is sitting on stretcher comfortably.
Right hand and fingers Full Range of Motion (able to use all finger and wrist flexors). Intact neurovascular exam. Posterior Ecchymosis of the 3rd, 4th and 5th proximal metacarpal area. Moderate 4th and 5th proximal metacarpal tenderness and mild edema. No erythema or bone deformity. No carpal tenderness.

Imaging:
Closed intra-articular avulsion fracture of the base of the right fifth metacarpal. No evidence of Carpal-Metacarpal subluxation or dislocation.

Patient was treated with an ulnar splint and referred to orthopedics for cast immobilization. Patient was referred to Behavioral Health due to concerns for anger management.

5th Metacarpal base avulsion fracture
Pearls:
• Metacarpal fractures are 18–44% of all hand fractures. The fifth metacarpal is the most commonly involved.
• The neck is the site mostly affected.
• Men are more likely to be affected. Punching or longitudinally direct force injury are the common mechanisms.
• Metacarpal base fractures are rare and have minimal consequence because the motion of the joint is small.
• For diagnosis, three radiographic views (posterior-anterior or anterior posterior, lateral and oblique) are required.
• Metacarpal injuries are mostly stable, isolated and rarely require surgery.
• Positioning of the metacarpal joints during immobilization does not appear to affect the outcome.
• More invasive treatment is required when:
  • Irreducible fractures that re-displace following reduction or those which are subacute (greater than 3–4 weeks from injury) or failure to achieve successful closed reduction with residual malrotation and substantial shortening.
  • Fractures >1 mm articular step-off or involvement of more than 25% of the articular surface.
  • Head/articular involvement and comminuted fractures.
  • When the articular surface is not amenable to repair.
  • Shaft fractures that include greater than 10° of angulation in the index or middle finger, or greater than 30°–40° of angulation in the ring or 40° in the fifth finger. Neck fractures that include >10° in the index and middle finger, greater than 30° in the ring finger and 50° in the fifth finger.
• Treatment for a Boxer’s fracture (neck metacarpal fractures) varies based on whether the fracture is open or closed, the degree of angulation, rotation, and other concomitant injuries.
• Immobilization with an ulnar gutter splint may be the definitive treatment for closed, non-displaced fractures without angulation or rotation.

Continued on next page
For the Urgent Care Provider:

- Semi-pronation oblique views should be obtained to evaluate the index and middle finger metacarpals, while semi-supination will allow for evaluation of the small and ring finger metacarpals. Computed tomography (CT) is indicated only in complex fractures or Carpal-Metacarpal fracture-dislocation.
- Conservative management options include ulnar gutter splint, buddy taping to the ring finger with immediate motion or 4 weeks of immobilization in a splint or cast. The length of immobilization should be based on tenderness on clinical exam since X-rays will lag behind clinical healing.
- Boxer’s fractures have a high risk of infection from “fight bite”, even very small wounds should be thoroughly irrigated, and there should be a low threshold for antibiotic treatment.
- Clinicians should be familiarized when to refer for surgery or higher level of care.
- Displaced intra-articular fractures, polytrauma, severe soft tissue injury, open fractures, segmental bone loss, and multiple hand or wrist fractures should be referred to higher level of care.

REFERENCES


Pearls from a Practicing Pediatrician – “Coronavirus COVID-19 and Multisystem Inflammatory Syndrome in Children (MIS-C)”

Thomas W. Tryon, MD, MBA, FAAP, FCUCM; UCA Board Member & Pediatric Section Chair

Approximately one month ago, the Centers for Disease Control & Prevention (CDC) issued a health advisory to alert providers to a rare but serious complication in children and young adults infected with SARS-CoV-2 called Multisystem Inflammatory Syndrome in Children (MIS-C). This syndrome, though to be triggered by prior exposure to SARS-CoV-2, is an inflammatory response with multiple organ dysfunction. As of the middle of May, MIS-C had been identified by the CDC in 19 states and in the District of Columbia.

The CDC is requesting that healthcare providers report to local, state and territorial health departments any patient who meets the case definition of MIS-C. Here is the CDC case definition:

**Case Definition for Multisystem Inflammatory Syndrome in Children (MIS-C)**

- An individual aged <21 years presenting with fever, laboratory evidence of inflammation, and evidence of clinically severe illness requiring hospitalization, with multisystem (≥2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological); AND
- No alternative plausible diagnoses; AND
- Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology or antigen test; or COVID-19 exposure within the 4 weeks prior to the onset of symptoms

The CDC defines fever for MIS-C as ≥38.0°C for ≥24 hours, or a report of a subjective fever lasting ≥24 hours. They also define laboratory evidence of inflammation as including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin. Additionally, the CDC recommends considering MIS-C in any pediatric death with evidence of SARS-CoV-2 infection.

Interestingly, MIS-C may mimic a number of conditions such as Kawasaki’s Disease, tick-borne illnesses, bacterial illnesses, toxic shock syndrome and, though rare, hemophagocytic lymphohistiocytosis (HLH). MIS-C can also present with acute abdomen symptoms that may mimic gastroenteritis or acute appendicitis. As for HLH, it is a condition that can be triggered by infections, autoimmune disease, malignancies, and results in cytokine overproduction related to natural killer and cytotoxic T-cell dysregulation.

With Summer 2020 now in full swing, while we have not been cleared of all COVID-19 related illness, this is the time of even greater diagnostic challenges in evaluating a child presenting with fever, especially if associated with a rash and/or mucous membrane changes. It will be important to develop a thoughtful differential diagnosis while utilizing clinical and laboratory clues to identify those with potential multi-organ dysfunction. Being connected with your friendly local or regional pediatric infectious disease specialist may also be of significant benefit. Best wishes as you continue to provide front line care for patients in what has been to this point quite an unusual and challenging year.

Antibiotic Stewardship Champion Award

The College of Urgent Care Medicine in conjunction with UCA and the Urgent Care Foundation proudly announce a new individual award to recognize the clinician who supports the practice of prescribing the correct antibiotic for the appropriate diagnosis, at the correct dosage and for the shortest duration while assuring it will be effective. Also saying no when antibiotics are not needed. Congratulations to the July Antibiotic Stewardship Champion Award recipient, Michael Green, MD of Northwell Health-GoHealth Urgent Care! Learn how to nominate an individual for the award at https://www.ucaoa.org/ABSChamp

Michael Green, MD was born and raised in Queens, NY. He completed his undergraduate at Adelphi University and went on to complete a Masters from Long Island University and North Shore University Hospital in Cardiovascular Perfusion. He continued his education at Ross University where he earned his Medical Degree. Dr. Green then pursued an Advanced Post Graduate Certificate from NYU in Health Policy and Management. Finally, he completed his Family Medicine Residency training at Robert Wood Johnson in NJ, where he was the Chief Resident. Upon graduating he received the RWJ Clinical Excellence Award.

He joined GoHealth Urgent Care in 2017 and since has been an integral part of the GoHealth NY team. Dr. Green has been recognized for his quality and leadership skills and as such in April 2020 he became the Associate Medical Director for Queens and Westchester. Furthermore, he helped start the GoEducate series, a GoHealth National weekly internal education publication. He is the lead editor for the publication.

Dr. Green has been appointed as Assistant Clinical Professor of Family Medicine at Zucker School of Medicine at Hofstra University/Northwell University. He has been recognized as an Active Teacher in Family Medicine by the American Academy of Family Physicians for his work with the Northwell Family Medicine Residencies.

Dr. Green is the July Antibiotic Stewardship Champion Award recipient for many reasons, including:

- Leads a team of 9 providers at Northwell GoHealth Urgent Care in NY to review charts. Reviews 900+ charts monthly from 240+ providers within their urgent care system. Once an individual's charts are reviewed an educational email is sent to the provider discussing appropriate and inappropriate use of antibiotics. Dr. Green, along with his team contributed to Northwell GoHealth Urgent Care's 83% appropriate antibiotic stewardship, exceeding national emergency room and urgent care metrics.

- Lead editor and frequent author for the GoEducate project, an internal publication for urgent care related topic reviews. This educational material is sent to over 700+ national GoHealth urgent care providers on a weekly basis with most educational materials stressing antibiotic stewardship. Also regularly teaches antibiotic stewardship to residents, medical students, and patients.

- GoHealth urgent care also utilizes a monthly score card for antibiotic stewardship, and recently Dr. Green's personal inappropriate antibiotic use was 0.00%, and was in the 100 percentile for GoHealth NY with total antibiotic use being 18.39% and recognized as a low antibiotic utilizer in our market.

Attention Physicians, Nurse Practitioners and Physician Assistants

Stand up and be recognized for your commitment to the Urgent Care specialty!

Are you a physician, nurse practitioner or physician assistant who is committed to the specialty of Urgent Care as your career? Are you a contributing member of the College of Urgent Care Medicine and the Urgent Care Association? You should be recognized for your achievement!

Applications are now being accepted for Fellowship in the College of Urgent Care Medicine. Qualified applicants will have demonstrated a solid foundation in Urgent Care Medicine and a commitment to CUCM. When accepted, you will be inducted and can then present yourself as a Fellow with the initials “FCUCM”. You will join the ranks of current fellows who continue to advance our specialty every day.

Details and criteria for applicants can be found here: https://www.ucaoa.org/Fellowship
Continuing Medical Education (CME)

Target Audience
This CME activity is intended for medical professionals who practice medicine in the on-demand space including urgent care, retail medicine and other similar venues. These providers may include physicians, nurse practitioners, and physician assistants.

Designation Statement
The Urgent Care Association (UCA) designates this enduring material activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only commensurate with the extent of their participation in the activity. Credit may be claimed for one year from the date of release of this issue.

CME Objectives
1. Provide updates on the diagnosis and treatment of clinical conditions commonly managed by on-demand providers
2. Alert on-demand providers to potential unusual cases that may present to them
3. Utilize tips and tricks to improve patient care in the on-demand space

Accreditation Statement
This activity has been planned and implemented in accordance with the accreditation requirement and policies of the Accreditation Council for Continuing Medical Education (ACCME) though the joint providership of the Urgent Care Association and the College of Urgent Care Medicine. UCA is accredited by the ACCME to provide continuing medical education for physicians.

CME Credit Instructions
Once you have read the article, please log into your UCA profile. Once you are logged in go to Manage My Account -> My Library. Now you will be logged into the UCA Online Education Library.
Go to Course Catalog -> Clinical -> Urgent Caring CME. Click on the Urgent Caring edition for this month. You will need to score 60% on the Quiz and complete the Survey to obtain credit.
Your certificate will show up under My Library -> Credits.
Please email education@ucaoa.org with questions.

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Disclaimer
Medical practice and knowledge is constantly evolving and changing. This information is peer reviewed but should not be your only source. Providers of care should use discretion when applying knowledge to any individual patient.
CME Questions*

1. Which of the following statements is correct?
   a. Positioning of the Metacarpal joints during immobilization does not appear to affect the outcome
   b. Metacarpal injuries are mostly unstable and commonly require surgery
   c. Semi-pronation oblique views should be obtained to evaluate the 4th and 5th finger metacarpals
   d. Shaft fractures that include greater than 5° of angulation in the index or middle finger require surgery

2. Which of the following is the most common location of fracture of the fifth metacarpal?
   a. Distal one-third
   b. Base
   c. Articular surface
   d. Shaft

3. The following is a rare but dangerous problem related to COVID-19 infection:
   a. Kawasaki
   b. Harley syndrome
   c. MIS-C
   d. SARS-4

4. Which of the following is a sign of the problem referred to in question 3:
   a. conjunctivitis
   b. otitis externa
   c. strawberry tongue
   d. nailbed pain

Answers from last month

1. Which statement is true when de-labeling penicillin allergic patients?
   a. It should be attempted for all patients with penicillin allergy reactions
   b. Clinicians should monitor patients for 60 min after oral challenge
   c. Every patient with an allergic reaction to penicillin should undergo penicillin skin testing and/or evaluation by an allergist
   d. Penicillin allergy testing utilizes a 4-tier testing approach as the gold standard for diagnosing penicillin allergy

2. Which of the following statements is correct:
   a. Remove a tick by crushing it with fingers
   b. Ticks do not remain active during freezing temperatures
   c. Thrombocytopenia Syndrome Virus has a 12% fatality rate
   d. Tumble clothes in a dryer on high heat for 5 minutes to kill ticks on dry clothing after you come indoors

3. Which of the following does Dr. Bhogal suggest is needed to get through these tough times:
   a. Research
   b. Hope
   c. Attention to detail
   D. Persistence

4. Return to highly competitive activity should be carefully considered after COVID-19 due to concerns about effects on the?
   a. Kidneys
   b. Lungs
   c. Heart
The College of Urgent Care Medicine (CUCM), formally known as the Urgent Care College of Physicians (UCCOP), was founded by physicians from the Urgent Care Association (UCA) to provide a clinician voice for the specialty. CUCM and UCA continue to work closely to advance the clinical practice of urgent care medicine. In 2016 the UCCOP board voted to include physician assistants and nurse practitioners as members. Thus in early 2017 the decision to change our name was made.

### Mission Statement

We are urgent care clinicians inspiring excellence in patient care and advancing the specialty through education, advocacy, and research.